ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES / PHYSICIAN OWNERSHIP / HIPAA

Patient Name: _____ DOB: _____ Pt Number: _____

1._____ I understand that it is my responsibility to provide Advanced Family Foot and Ankle ("AFFA") with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). AFFA is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify AFFA immediately upon any change in my
insurance.

2._____ I understand that in consideration of the services provided, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at AFFA which are not covered or reimbursed by my insurance. Furthermore, I am responsible for any applicable deductible, co-payments, and/or coinsurance prior to the provision of services. AFFA will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.

If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form for non-covered services. Should my account be referred to a collection agency or attorney for collection, I agree to pay all costs of collection, including interest and attorney's fees and costs.

3._____ I authorize my insurance carrier to release information regarding my coverage to AFFA. I also authorize agents of any hospital, treatment center or previous physician(s) to furnish AFFA copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician, other health professional or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within AFFA.

4._____ My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to AFFA. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my
insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to AFFA.

5. _____ I acknowledge that I have received a copy of the AFFA's *Physician Ownership Disclosure*.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") ACKNOWLEDGEMENT AFFA is required by law to provide you with a copy of our *Notice of Privacy Practices*, which describes how your health care information is used and disclosed.

To ensure our records are accurate, please complete and sign below and return this form to our receptionist to acknowledge that you have been provided with a copy of our Notice. Also, please be advised AFFA may use and disclose de-identified health information for purposes of data collection and statistical analysis. De-identified information is information from which all personal identification has been removed. T

This means the health information can no longer be identified as yours and is no longer considered protected under HIPAA. I acknowledge the use or disclosure of my Protected Health Information by AFFA for the purposes of Treatment, Payment, and Health Care Operations.

I have received a copy of the Notice of Privacy Practices and understand I have the right to review prior to signing this document.

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES/ PHYSICIAN OWNERSHIP/ HIPAA

I authorize the following people to be involved in my care that may require a disclosure of Protected Health Information. This consent for disclosure includes both health and financial information as it relates to my care.

CONTACTS

Name:_____ Relationship:_____ Ph: Cell: _____

Name:_____ Relationship:_____ Ph: Cell: _____

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.
I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THE ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES AGREEMENT, AS WELL AS THE PHYSICIAN OWNERSHIP DISCLOSURE AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ACKNOWLEDGEMENT.

Patient Signature/Representative: _____ Date:

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Social Security Number: _____

Last: _____ First: _____ MI: ____ Suffix: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: ☐ M ☐ F DOB: _____ Birthplace: _____

E-mail Address: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

MARITAL STATUS:

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Unmarried Partners

EMPLOYMENT STATUS:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ Military Duty ☐ Disabled

Occupation: _____

Employer: _____ Employer Contact #: _____

STUDENT:

☐ Full Time ☐ Part Time ☐ Not A Student

RACE:

☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Do not wish to provide

ETHNICITY:

☐ Hispanic ☐ Not Hispanic ☐ Do not wish to provide

PREFERRED LANGUAGE:

☐ English ☐ Other _____ ☐ Do not wish to provide

EMERGENCY CONTACT INFORMATION:

Relationship: _____ Last: _____ First: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Care Facility: _____

Patient Signature/Representative: _____ **Date:** _____

Patient Name: _____ DOB: _____

CURRENT MEDICATIONS / SUPPLEMENTS AND ALLERGIES PLEASE BE SPECIFIC				
If start/stop dates unknown, please give approximate month and year				
Medication - Name of Drug Include Prescription & Over the Counter	**Strength of Drug**	**Daily Dose How Taken (BE SPECIFIC)**	**Date Started**	**Prescribing Doctor (FIRST, LAST)**
Example: Enter your medication here	XX mg	X per day	01 / 01 / 2000	Dr Sample Smith
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	
			___/___/_____	

Allergies	Reaction	Severe Moderate Mild
Example: Penicillin	Breathing Difficulties	☐ **Severe** ☒ **Moderate** ☐ **Mild**
		☐ **Severe** ☐ **Moderate** ☐ **Mild**
		☐ **Severe** ☐ **Moderate** ☐ **Mild**
		☐ **Severe** ☐ **Moderate** ☐ **Mild**
		☐ **Severe** ☐ **Moderate** ☐ **Mild**
		☐ **Severe** ☐ **Moderate** ☐ **Mild**

01/2012

Height:_____ Weight:_____ Shoe Size:_____

Primary Care Physician:_____ Date Last Seen:_____

E-PRESCRIBING CONSENT FORM

STAFF USE ONLY

Patient Name: _____ DOB: _____Form Completed By: _____

The US Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing reduces medication errors while enhancing patient care. ADVANCED FAMILY FOOT & ANKLE will now be electronically prescribing medications. Please provide your preferred pharmacy's information below.

Pharmacy Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____ State: _____ Zip: _____

General Consent for Treatment

As a patient of Advanced Family Foot and Ankle I hereby request and authorize the physicians and staff to provide me with the recommended medical, diagnostic, and surgical treatment as they deem necessary.

I am aware that the practice of medicine is not an exact science and I acknowledge that NO guarantees have been made to me as the result of any medical examinations or treatments. I am also aware that in the practice of medicine other unexpected risks or complications not discussed may occur. I also understand that during the course of any proposed procedure or treatment, unforeseen conditions may be revealed requiring the performance of additional procedures. If additional procedures are required in non-emergency circumstances I will be provided with additional educational information so I may make an informed decision. Additional consent forms may be provided to me.

I understand that all information pertaining to my care will remain a confidential part of my medical record as it relates to the Health Insurance Portability and Accountability Act.

Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Date:
Referring Physician:	Primary Care Physician:	

REASON FOR VISIT

CURRENT SYMPTOMS

Please mark with an (x) any illnesses or medical problems you have, or have had, **within the past year.**

SYMPTOMS	Y	N	SYMPTOMS	Y	N	SYMPTOMS	Y	N
GENERAL			**RESPIRATORY**			**NEUROLOGIC**		
Weakness	☐	☐	Cough Up Blood	☐	☐	Headaches	☐	☐
Tiredness	☐	☐	Wheezing	☐	☐	Blackouts	☐	☐
Poor Appetite	☐	☐	Shortness of Breath	☐	☐	Dizziness	☐	☐
Weight Loss	☐	☐	**CARDIOVASCULAR**			Loss of Balance	☐	☐
Fever	☐	☐	Chest Pain	☐	☐	Numbness	☐	☐
Night Sweats	☐	☐	High Blood Pressure	☐	☐	**PSYCHIATRIC**		
BREASTS			Irregular Heartbeat	☐	☐	Nervousness	☐	☐
Lumps	☐	☐	**GASTROINTESTINAL**			Depression	☐	☐
Pain	☐	☐	Nausea	☐	☐	Difficulty Sleeping	☐	☐
Discharge	☐	☐	Vomiting	☐	☐	Stress	☐	☐
EYES, EARS, NOSE, THROAT			Diarrhea	☐	☐	**MUSCULOSKELETAL**		
Change in Vision	☐	☐	Constipation	☐	☐	Painful Joints	☐	☐
Difficulty Hearing	☐	☐	Heartburn	☐	☐	Muscle Pain	☐	☐
Nose Bleeds	☐	☐	Abdominal Pain	☐	☐	Back Pain	☐	☐
Hoarseness	☐	☐	Bright Red Blood in Stools	☐	☐	**BLOOD**		
URINARY			Black Stools	☐	☐	Anemia	☐	☐
Pain or Burning w/Urination	☐	☐	Change in Bowel Habits	☐	☐	Easy Bruising	☐	☐
Frequent Urination	☐	☐	**SKIN**			Prolonged Bleeding	☐	☐
Kidney Stones	☐	☐	Itching	☐	☐	Blood Clots	☐	☐
Blood in Urine	☐	☐	Rash	☐	☐	Transfusions	☐	☐

PAIN SCALE: **Please rate your pain from 0 to 10 0 = No Pain 10 = Very Severe**

"I rate my pain as number _____"

Location of pain: _____

FOR WOMEN ONLY

Onset of Menstruation:		Number of Live Births:	
Date of Last Menstrual Cycle:		Abnormal Menstruation?	
Number of Pregnancies:		Hot Flashes?	
Age at First Pregnancy:		Date of First Menstrual Cycle:	

PAST MEDICAL HISTORY

Please circle any illnesses or medical problems you have now or have had in the past and indicate the year each started. If this has occurred within the last three (3) years, add an asterisk (*).

ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Pneumonia		High Blood Pressure		Neurologic Disorders/Stroke	
Diabetes		Liver Disease		Emotional Disorders	
Blood Disorders		Thyroid Disease		HIV Positive/AIDS	
Heart Disease (CHF, MI)		Cancer		Tuberculosis	
Kidney Disease		Skin Disease		Other:	

Other:

SURGERIES/HOSPITALIZATIONS / INJURIES

List all hospitalizations, operations, tests, procedures, and severe injuries

Date	Type of Operation, Test, Procedure, or Severe Injury	Physician & Medical Facility

SOCIAL HISTORY

Marital Status:	Occupation:	Live Alone: ☐ Yes ☐ No

SUBSTANCE USE / HABITS

If Current, List Again with *Current Meds/Supplements*

	Y	N	Type	How much / How often	Quit?
Recreational Drug Use					
Tobacco					
Alcohol					

RECENT DIAGNOSTIC TESTS

Test	Date of Test	Medical Facility
CAT Scans / X-Rays:		
PET Scans / Bone Scans:		
Ultrasound(s):		

MRI(s):		
Other (Specify):		
Other (Specify):		

Additional Studies: _____

_____

Have you ever been advised to have a test, procedure, or surgery, but decided against it? ☐ Yes ☐ No
If "yes," please explain: _____

_____

FAMILY HISTORY

Has any blood relative ever experienced any of the following conditions?

Cancer (Specify Type) or Blood Clots	Who (ie. Mother)	Age at Diagnosis

OTHER FAMILY MEDICAL HISTORY / CONDITIONS

	Age	Health Conditions (ie. Diabetes)	Deceased	Age of Death	Cause of Death
Father:					
Mother:					
Brother ☐ Sister ☐					
Brother ☐ Sister ☐					
Brother ☐ Sister ☐					
Brother ☐ Sister ☐					
Brother ☐ Sister ☐					

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____